TITLE 26. HEALTH AND VITAL STATISTICS
CHAPTER 2H. HEALTH CARE FACILITIES
ARTICLE IV. ADVANCE DIRECTIVES FOR HEALTH CARE

N.J. Stat. § 26:2H-53 (2009)

§ 26:2H-53. Short title

This act shall be known and may be cited as the "New Jersey Advance Directives for Health Care Act."

§ 26:2H-54. Findings, declarations

The Legislature finds and declares that:

a. Competent adults have the fundamental right, in collaboration with their health care providers, to control decisions about their own health care. This State recognizes, in its law and public policy, the personal right of the individual patient to make voluntary, informed choices to accept, to reject, or to choose among alternative courses of medical and surgical treatment.

b. Modern advances in science and medicine have made possible the prolongation of the lives of many seriously ill individuals, without always offering realistic prospects for improvement or cure. For some individuals the possibility of extended life is experienced as meaningful and of benefit. For others, artificial prolongation of life may seem to provide nothing medically necessary or beneficial, serving only to extend suffering and prolong the dying process. This State recognizes the inherent dignity and value of human life and within this context recognizes the fundamental right of individuals to make health care decisions to have life-prolonging medical or surgical means or procedures provided, withheld, or withdrawn.

c. In order that the right to control decisions about one's own health care should not be lost in the event a patient loses decision making capacity and is no longer able to participate actively in making his own health care decisions, this State recognizes the right of competent adults to plan ahead for health care decisions through the execution of advance directives, such as living wills and durable powers of attorney, and to have the wishes expressed therein respected, subject to certain limitations.

d. The right of individuals to forego life-sustaining measures is not absolute and is subject to certain interests of society. The most significant of these societal interests is the preservation of life, understood to embrace both an interest in preserving the life of the particular patient and a related but distinct interest in preserving the sanctity of all human life as an enduring social value. A second, closely related societal interest is the protection of individuals from direct and purposeful self-destruction, motivated by a specific intent to die. A third interest is the protection of innocent third parties who may be harmed by the patient's decision to forego therapy; this interest may be asserted to prevent the emotional and financial abandonment of the patient's minor children or to protect the paramount concerns of public health or safety. A fourth interest encompasses safeguarding the ethical integrity of the health care professions, individual professionals, and health care institutions, and maintaining public confidence and trust in the integrity and caring role of health care professionals and institutions. Finally, society has an interest in ensuring the soundness of health care decision making, including both protecting vulnerable patients from potential abuse or neglect and facilitating the exercise of informed and voluntary patient choice.

e. In accordance with these State interests, this State expressly rejects on both legal and moral grounds the practice of active euthanasia. No individual shall have the right to, nor shall any physician or other health care professional be authorized to engage in, the practice of active euthanasia.

f. In order to assure respect for patients' previously expressed wishes when the capacity to participate actively in decision making has been lost or impaired; to facilitate and encourage a sound decision making process in which patients, health care representatives, families, physicians, and other health care professionals are active participants; to properly consider patients' interests both in self-determination and in well-being; and to provide necessary and appropriate safeguards concerning the termination of life-sustaining treatment for incompetent patients as the law and public policy of this State, the Legislature hereby enacts the New Jersey Advance Directives for Health Care Act.

§ 26:2H-55. Definitions

As used in this act:

"Adult" means an individual 18 years of age or older.

"Advance directive for health care" or "advance directive" means a writing executed in accordance with the requirements of this act. An "advance directive" may include a proxy directive or an instruction directive, or both.

"Attending physician" means the physician selected by, or assigned to, the patient who has primary responsibility for the treatment and care of the patient.

"Decision making capacity" means a patient's ability to understand and appreciate the nature and consequences of health care decisions, including the benefits and risks of each, and alternatives to any proposed health care, and to reach an informed decision. A patient's decision making capacity is evaluated relative to the demands of a particular health care decision.

"Declarant" means a competent adult who executes an advance directive.

"Do not resuscitate order" means a physician's written order not to attempt cardiopulmonary resuscitation in the event the patient suffers a cardiac or respiratory arrest.

"Emergency care" means immediate treatment provided in response to a sudden, acute and unanticipated medical crisis in order to avoid injury, impairment or death.

"Health care decision" means a decision to accept or to refuse any treatment, service or procedure used to diagnose, treat or care for a patient's physical or mental condition, including life-sustaining treatment. "Health care decision" also means a decision to accept or to refuse the services of a particular physician, nurse, other health care professional or health care institution, including a decision to accept or to refuse a transfer of care.

"Health care institution" means all institutions, facilities, and agencies licensed, certified, or otherwise authorized by State law to administer health care in the ordinary course of business, including hospitals, nursing homes, residential health care facilities, home health care agencies, hospice programs operating in this State, mental health institutions, facilities or agencies, or institutions, facilities and agencies for the developmentally disabled. The term "health care institution" shall not be construed to include "health care professionals" as defined in this act.

"Health care professional" means an individual licensed by this State to administer health care in the ordinary course of business or practice of a profession.

"Health care representative" means the individual designated by a declarant pursuant to the proxy directive part of an advance directive for the purpose of making health care decisions on the declarant's behalf, and includes an individual designated as an alternate health care representative who is acting as the declarant's health care representative in accordance with the terms and order of priority stated in an advance directive.

"Instruction directive" means a writing which provides instructions and direction regarding the declarant's wishes for health care in the event that the declarant subsequently lacks decision making capacity.

"Life-sustaining treatment" means the use of any medical device or procedure, artificially provided fluids and nutrition, drugs, surgery or therapy that uses mechanical or other artificial means to sustain, restore or supplant a vital bodily function, and thereby increase the expected life span of a patient.

"Other health care professionals" means health care professionals other than physicians and nurses.

"Patient" means an individual who is under the care of a physician, nurse or other health care professional.

"Permanently unconscious" means a medical condition that has been diagnosed in accordance with currently accepted medical standards and with reasonable medical certainty as total and irreversible loss of consciousness and capacity for interaction with the environment. The term "permanently unconscious" includes without limitation a persistent vegetative state or irreversible coma.

"Physician" means an individual licensed to practice medicine and surgery in this State.

"Proxy directive" means a writing which designates a health care representative in the event the declarant subsequently lacks decision making capacity.

"State" means a state, territory, or possession of the United States, the District of Columbia, or the Commonwealth of Puerto Rico.

"Terminal condition" means the terminal stage of an irreversibly fatal illness, disease or condition. A determination of a specific life expectancy is not required as a precondition for a diagnosis of a "terminal condition," but a prognosis of a life expectancy of six months or less, with or without the provision of life-sustaining treatment, based upon reasonable medical certainty, shall be deemed to constitute a terminal condition.

§ 26:2H-56. Advance directive for health care; execution

A declarant may execute an advance directive for health care at any time. The advance directive shall be signed and dated by, or at the direction of, the declarant in the presence of two subscribing adult witnesses, who shall attest that the declarant is of sound mind and free of duress and undue influence. A designated health care representative shall not act as a witness to the execution of an advance directive. Alternatively, the advance directive shall be signed and dated by, or at the direction of, the declarant and be acknowledged by the declarant before a notary public, attorney at law, or other person authorized to administer oaths. An advance directive may be supplemented by a video or audio tape recording. A female declarant may include in an advance directive executed by her, information as to what effect the advance directive shall have if she is pregnant.

§ 26:2H-57. Proxy, instruction directive; reaffirmed, modified, revoked

a. A declarant may reaffirm or modify either a proxy directive, or an instruction directive, or both. The reaffirmation or modification shall be made in accordance with the requirements for execution of an advance directive pursuant to section 4 of this act.

b. A declarant may revoke an advance directive, including a proxy directive, or an instruction directive, or both, by the following means:

(1) Notification, orally or in writing, to the health care representative, physician, nurse or other health care professional, or other reliable witness, or by any other act evidencing an intent to revoke the document; or

(2) Execution of a subsequent proxy directive or instruction directive, or both, in accordance with section 4 of this act.

c. Designation of the declarant's spouse as health care representative shall be revoked upon divorce or legal separation, and designation of the declarant's domestic partner as defined in section 3 of P.L.2003, c.246 (C.26:8A-3) as health care representative shall be revoked upon termination of the declarant's domestic partnership, unless otherwise specified in the advance directive.

d. An incompetent patient may suspend an advance directive, including a proxy directive, an instruction directive, or both, by any of the means stated in paragraph (1) of subsection b. of this section. An incompetent patient who has suspended an advance directive may reinstate that advance directive by oral or written notification to the health care representative, physician, nurse or other health care professional of an intent to reinstate the advance directive.

e. Reaffirmation, modification, revocation or suspension of an advance directive is effective upon communication to any person capable of transmitting the information including the health care representative, the attending physician, nurse or other health care professional responsible for the patient's care.

§ 26:2H-58. Designation of health care representative; limitations

a. A declarant may execute a proxy directive, pursuant to the requirements of section 4 of this act, designating a competent adult to act as his health care representative.

(1) A competent adult, including, but not limited to, a declarant's spouse, domestic partner as defined in section 3 of P.L. 2003, c. 246 (C. 26:8A-3), adult child, parent or other family member, friend, religious or spiritual advisor, or other person of the declarant's choosing, may be designated as a health care representative.

(2) An operator, administrator or employee of a health care institution in which the declarant is a patient or resident shall not serve as the declarant's health care representative unless the operator, administrator or employee is related to the declarant by blood, marriage, domestic partnership or adoption.

This restriction does not apply to a physician, if the physician does not serve as the patient's attending physician and the patient's health care representative at the same time.

(3) A declarant may designate one or more alternate health care representatives, listed in order of priority. In the event the primary designee is unavailable, unable or unwilling to serve as health care representative, or is disqualified from such service pursuant to this section or any other law, the next designated alternate shall serve as health care representative. In the event the primary designee subsequently becomes available and able to serve as health care representative, the primary designee may, insofar as then practicable, serve as health care representative.

(4) A declarant may direct the health care representative to consult with specified individuals, including alternate designees, family members and friends, in the course of the decision making process.

(5) A declarant shall state the limitations, if any, to be placed upon the authority of the health care representative including the limitations, if any, which may be applicable if the declarant is pregnant.

b. A declarant may execute an instruction directive, pursuant to the requirements of section 4 of this act, stating the declarant's general treatment philosophy and objectives; or the declarant's specific wishes regarding the provision, withholding or withdrawal of any form of health care, including life-sustaining treatment; or both. An instruction directive may, but need not, be executed contemporaneously with, or be attached to, a proxy directive.

§ 26:2H-59. Conditions under which advance directive becomes operative

a. An advance directive becomes operative when (1) it is transmitted to the attending physician or to the health care institution, and (2) it is determined pursuant to section 8 of this act that the patient lacks capacity to make a particular health care decision.

b. Treatment decisions pursuant to an advance directive shall not be made and implemented until there has been a reasonable opportunity to establish, and where appropriate confirm, a reliable diagnosis and prognosis for the patient.

§ 26:2H-60. Determination of patient's capacity to make a health care decision

a. The attending physician shall determine whether the patient lacks capacity to make a particular health care decision. The determination shall be stated in writing, shall include the attending physician's opinion concerning the nature, cause, extent, and probable duration of the patient's incapacity, and shall be made a part of the patient's medical records.

b. The attending physician's determination of a lack of decision making capacity shall be confirmed by one or more physicians. The opinion of the confirming physician shall be stated in writing and made a part of the patient's medical records in the same manner as that of the attending physician. Confirmation of a lack of decision making capacity is not required when the patient's lack of decision making capacity is clearly apparent, and the attending physician and the health care representative agree that confirmation is unnecessary.

c. If the attending physician or the confirming physician determines that a patient lacks decision making capacity because of a mental or psychological impairment or a developmental disability, and neither the attending physician or the confirming physician has specialized training or experience in diagnosing mental or psychological conditions or developmental disabilities of the same or similar nature, a determination of a lack of decision making capacity shall be confirmed by one or more physicians with appropriate specialized training or experience. The opinion of the confirming physician shall be stated in writing and made a part of the patient's medical records in the same manner as that of the attending physician.

d. A physician designated by the patient's advance directive as a health care representative shall not make or confirm the determination of a lack of decision making capacity.

e. The attending physician shall inform the patient, if the patient has any ability to comprehend that he has been determined to lack decision making capacity, and the health care representative that: (1) the patient has been determined to lack decision making capacity to make a particular health care decision; (2) each has the right to contest this determination; and (3) each may have recourse to the dispute resolution process established by the health care institution pursuant to section 14 of this act.

Notice to the patient and the health care representative shall be documented in the patient's medical records.

f. A determination of lack of decision making capacity under this act is solely for the purpose of implementing an advance directive in accordance with the provisions of this act, and shall not be construed as a determination of a patient's incapacity or incompetence for any other purpose.

g. For purposes of this section, a determination that a patient lacks decision making capacity shall be based upon, but need not be limited to, evaluation of the patient's ability to understand and appreciate the nature and consequences of a particular health care decision, including the benefits and risks of, and alternatives to, the proposed health care, and to reach an informed decision.

§ 26:2H-61. Authority to make health care decisions

a. If it has been determined that the patient lacks decision making capacity, a health care representative shall have authority to make health care decisions on behalf of the patient. The health care representative shall act in good faith and within the bounds of the authority granted by the advance directive and by this act.

b. If a different individual has been appointed as the patient's legal guardian, the health care representative shall retain legal authority to make health care decisions on the patient's behalf, unless the terms of the legal guardian's court appointment or other court decree provide otherwise.

c. The conferral of legal authority on the health care representative shall not be construed to impose liability upon the health care representative for any portion of the patient's health care costs.

d. An individual designated as a health care representative or as an alternate health care representative may decline to serve in that capacity.

e. The health care representative shall exercise the patient's right to be informed of the patient's medical condition, prognosis and treatment options, and to give informed consent to, or refusal of, health care.

f. In the exercise of these rights and responsibilities, the health care representative shall seek to make the health care decision the patient would have made had he possessed decision making capacity under the circumstances, or, when the patient's wishes cannot adequately be determined, shall make a health care decision in the best interests of the patient.

§ 26:2H-62. Rights, responsibilities of health care professionals

In addition to any rights and responsibilities recognized or imposed by, or pursuant to, this act, or by any other law, physicians, nurses, and other health care professionals shall have the following rights and responsibilities:

a. The attending physician shall make an affirmative inquiry of the patient, his family or others, as appropriate under the circumstances, concerning the existence of an advance directive. The attending physician shall note in the patient's medical records whether or not an advance directive exists, and the name of the patient's health care representative, if any, and shall attach a copy of the advance directive to the patient's medical records. The attending physician shall document in the same manner the reaffirmation, modification, or revocation of an advance directive, if he has knowledge of such action.

b. A physician may decline to participate in the withholding or withdrawing of measures utilized to sustain life, in accordance with his sincerely held personal or professional convictions. In such circumstances, the physician shall act in good faith to inform the patient and the health care representative, and the chief of the medical staff or other designated institutional official, of this decision as soon as practicable, to effect an appropriate, respectful and timely transfer of care, and to assure that the patient is not abandoned or treated disrespectfully.

In the event of transfer of a patient's care, the attending physician shall assure the timely transfer of the patient's medical records, including a copy of the patient's advance directive.

c. A nurse or other health care professional may decline to participate in the withholding or withdrawing of measures utilized to sustain life, in accordance with his sincerely held personal or professional convictions. In these circumstances, the nurse or other health care professional shall act in good faith to inform the patient and the health care representative, and the head of the nursing or other professional staff or other designated institutional official, of this decision as soon as practicable, to cooperate in effecting an appropriate, respectful and timely transfer of care, and to assure that the patient is not abandoned or treated disrespectfully.

d. Nothing in this act shall be construed to require a physician, nurse or other health care professional to begin, continue, withhold, or withdraw health care in a manner contrary to law or accepted professional standards.

§ 26:2H-63. Decision making under an advance directive

a. The attending physician, the health care representative and, when appropriate, any additional physician responsible for the patient's care, shall discuss the nature and consequences of the patient's medical condition, and the risks, benefits and burdens of the proposed health care and its alternatives. Except as provided by subsection b. of this section, the attending physician shall obtain informed consent for, or refusal of, health care from the health care representative.

(1) Discussion of the proposed treatment and its alternatives shall include, as appropriate under the circumstances, the availability, benefits and burdens of rehabilitative treatment, therapy, and services.

(2) The decision making process shall allow, as appropriate under the circumstances, adequate time for the health care representative to understand and deliberate about all relevant information before a treatment decision is implemented.

b. Following a determination that a patient lacks decision making capacity, the health care representative and the attending physician shall, to a reasonable extent, discuss the treatment options with the patient, and seek to involve the patient as a participant in the decision making process. The health care representative and the attending physician shall seek to promote the patient's capacity for effective participation and shall take the patient's expressed wishes into account in the decision making process.

Once decision making authority has been conferred upon a health care representative pursuant to an advance directive, if the patient is subsequently found to possess adequate decision making capacity with respect to a particular health care decision, the patient shall retain legal authority to make that decision. In such circumstances, the health care representative may continue to participate in the decision making process in an advisory capacity, unless the patient objects.

Notwithstanding any other provision of this act to the contrary, if a patient who lacks decision making capacity clearly expresses or manifests the contemporaneous wish that medically appropriate measures utilized to sustain life be provided, that wish shall take precedence over any contrary decision of the health care representative and any contrary statement in the patient's instruction directive.

c. In acting to implement a patient's wishes pursuant to an advance directive, the health care representative shall give priority to the patient's instruction directive, and may also consider, as appropriate and necessary, the following forms of evidence of the patient's wishes:

(1) The patient's contemporaneous expressions, including nonverbal expressions;

(2) Other reliable sources of information, including the health care representative's personal knowledge of the patient's values, preferences and goals; and

(3) Reliable oral or written statements previously made by the patient, including, but not limited to, statements made to family members, friends, health care professionals or religious leaders.

d. If the instruction directive, in conjunction with other evidence of the patient's wishes, does not provide, in the exercise of reasonable judgment, clear direction as applied to the patient's medical condition and the treatment alternatives, the health care representative shall exercise reasonable discretion, in good faith, to effectuate the terms, intent, and spirit of the instruction directive and other evidence of the patient's wishes.

e. Subject to the provisions of this act, and unless otherwise stated in the advance directive, if the patient's wishes cannot be adequately determined, then the health care representative shall make a health care decision in the patient's best interests.

§ 26:2H-64. Effect of instruction directive

a. If the patient has executed an instruction directive but has not designated a health care representative, or if neither the designated health care representative or any alternate designee is able or available to serve, the instruction directive shall be legally operative. If the instruction directive provides clear and unambiguous guidance under the circumstances, it shall be honored in accordance with its specific terms by a legally appointed guardian, if any, family members, the physicians, nurses, other health care professionals, health care institutions, and others acting on the patient's behalf.

b. If the instruction directive is, in the exercise of reasonable judgment, not specific to the patient's medical condition and the treatment alternatives, the attending physician, in consultation with a legally appointed guardian, if any, family members, or others acting on the patient's behalf, shall exercise reasonable judgment to effectuate the wishes of the patient, giving full weight to the terms, intent, and spirit of the instruction di-

rective. Departure from the specific terms and provisions of the instruction directive shall be based upon clearly articulable factors not foreseen or contemplated by the instruction directive, including, but not limited to, the circumstances of the patient's medical condition.

c. Nothing in this act shall be construed to impair the legal force and effect of an instruction directive executed prior to the effective date of this act.

§ 26:2H-65. Additional rights, responsibilities of health care institution

a. In addition to any rights and responsibilities recognized or imposed by, or pursuant to, this act, or any other law, a health care institution shall have the following rights and responsibilities:

(1) A health care institution shall adopt such policies and practices as are necessary to provide for routine inquiry, at the time of admission and at such other times as are appropriate under the circumstances, concerning the existence and location of an advance directive.

(2) A health care institution shall adopt such policies and practices as are necessary to provide appropriate informational materials concerning advance directives to all interested patients and their families and health care representatives, and to assist patients interested in discussing and executing an advance directive.

(3) A health care institution shall adopt such policies and practices as are necessary to educate patients and their families and health care representatives about the availability, benefits and burdens of rehabilitative treatment, therapy and services, including but not limited to family and social services, self-help and advocacy services, employment and community living, and use of assistive devices. A health care institution shall, in consultation with the attending physician, assure that such information is discussed with a patient and his health care representative and made a part of the decision making process set forth in section 11 of this act, as appropriate under the circumstances.

(4) In situations in which a transfer of care is necessary, including a transfer for the purpose of effectuating a patient's wishes pursuant to an advance directive, a health care institution shall, in consultation with the attending physician, take all reasonable steps to effect the appropriate, respectful and timely transfer of the patient to the care of an alternative health care professional or institution, as necessary, and shall assure that the patient is not abandoned or treated disrespectfully. In such circumstances, a health care institution shall assure the timely transfer of the patient's medical records, including a copy of the patient's advance directive.

(5) A health care institution shall establish procedures and practices for dispute resolution, in accordance with section 14 of this act.

(6) A health care institution shall adopt such policies and practices as are necessary to inform physicians, nurses and other health care professionals of their rights and responsibilities under this act, to assure that such rights and responsibilities are understood, and to provide a forum for discussion and consultation regarding the requirements of this act.

b. A private, religiously-affiliated health care institution may develop institutional policies and practices defining circumstances in which it will decline to participate in the withholding or withdrawing of specified measures utilized to sustain life. Such policies and practices shall be written, and shall be properly communicated to patients and their families and health care representatives prior to or upon the patient's admission, or as soon after admission as is practicable.

If the institutional policies and practices appear to conflict with the legal rights of a patient wishing to forego health care, the health care institution shall attempt to resolve the conflict, and if a mutually satisfactory accommodation cannot be reached, shall take all reasonable steps to effect the appropriate, timely and respectful transfer of the patient to the care of another health care institution appropriate to the patient's needs, and shall assure that the patient is not abandoned or treated disrespectfully.

c. Nothing in this act shall be construed to require a health care institution to participate in the beginning, continuing, withholding or withdrawing of health care in a manner contrary to law or accepted medical standards.

§ 26:2H-66. Resolution of disagreements

a. In the event of disagreement among the patient, health care representative and attending physician concerning the patient's decision making capacity or the appropriate interpretation and application of the terms of an advance directive to the patient's course of treatment, the parties may seek to resolve the disagreement by means of procedures and practices established by the health care institution, including but not limited to, consultation with an institutional ethics committee, or with a person designated by the health care institution for this purpose or may seek resolution by a court of competent jurisdiction.

b. A health care professional involved in the patient's care, other than the attending physician, or an administrator of a health care institution may also invoke the dispute resolution process established by the health care institution to seek to resolve a disagreement concerning the patient's decision making capacity or the appropriate interpretation and application of the terms of an advance directive.

§ 26:2H-67. Circumstances under which life-sustaining treatment may be withheld or withdrawn

a. Consistent with the terms of an advance directive and the provisions of this act, life-sustaining treatment may be withheld or withdrawn from a patient in the following circumstances:

(1) When the life-sustaining treatment is experimental and not a proven therapy, or is likely to be ineffective or futile in prolonging life, or is likely to merely prolong an imminent dying process;

(2) When the patient is permanently unconscious, as determined by the attending physician and confirmed by a second qualified physician;

(3) When the patient is in a terminal condition, as determined by the attending physician and confirmed by a second qualified physician; or

(4) In the event none of the above circumstances applies, when the patient has a serious irreversible illness or condition, and the likely risks and burdens associated with the medical intervention to be withheld or withdrawn may reasonably be judged to outweigh the likely benefits to the patient from such intervention, or imposition of the medical intervention on an unwilling patient would be inhumane. In such cases prior to implementing a decision to withhold or withdraw life-sustaining treatment, the attending physician may promptly seek consultation with an institutional or regional reviewing body in accordance with section 17 of this act, or may promptly seek approval of a public agency recognized by law for this purpose.

b. Nothing in this section shall be construed to impair the obligations of physicians, nurses and other health care professionals to provide for the care and comfort of the patient and to alleviate pain, in accordance with accepted medical and nursing standards.

c. Nothing in this section shall be construed to abridge any constitutionally-protected right to refuse treatment under either the United States Constitution or the Constitution of the State of New Jersey.

§ 26:2H-68. Issuance of do not resuscitate order

a. Consistent with the terms of an advance directive and the provisions of this act, the attending physician may issue a do not resuscitate order.

b. A do not resuscitate order shall be entered in writing in the patient's medical records prior to implementation of the order.

c. Nothing in this act shall be construed to impair any existing legal authority to issue a do not resuscitate order when the patient has not executed an advance directive.

§ 26:2H-69. Consultation with institutional or regional reviewing body

a. An institutional or regional reviewing body which engages in prospective case consultation pursuant to paragraph (4) of subsection a. of section 15 of this act may be consulted by the attending physician, patient or health care representative as to whether it believes that the withholding or withdrawal of the medical intervention under consideration would be in conformity with the requirements of this act, including without limitation: whether such action would be within the scope of the patient's advance directive; whether it may reasonably be judged that the likely risks and burdens associated with the medical intervention to be withheld or withdrawn outweigh its likely benefits; and whether it may reasonably be judged that imposition of the medical intervention on an unwilling patient would be inhumane. The attending physician, patient and health care representative shall also be advised of any other course of diagnosis or treatment recommended for consideration.

Consultation with the institutional or regional reviewing body shall be documented in the patient's medical records.

b. Consultation with an institutional or regional reviewing body acting in accordance with subsection a. of this section is not required. Furthermore, nothing in this act shall be construed to impair the right of a patient, health care representative, physician, nurse, or other health care professional who consults with an institutional or regional reviewing body to:

(1) Seek review by a public agency recognized by law for this purpose; or

(2) Seek review by a court of competent jurisdiction.

c. Nothing in this section shall preclude the transfer of the patient to another appropriate health care professional or health care institution. In this case the health care institution responsible for the patient's care shall assure that the health care professional or health care institution to which the patient is transferred is properly informed of the advice given by the institutional or regional reviewing body.

§ 26:2H-70. Existing law preserved; emergency care

a. Nothing in this act shall be construed to alter, amend or revoke the rights and responsibilities under existing law of health care institutions not governed by the provisions of this act.

b. The provisions of this act shall not be construed to require emergency personnel, including paid or volunteer fire fighters; paramedics; members of an ambulance team, rescue squad, or mobile intensive care unit; or emergency room personnel of a licensed health care institution, to withhold or withdraw emergency care in circumstances which do not afford reasonable opportunity for careful review and evaluation of an advance directive without endangering the life of the patient.

§ 26:2H-71. Rules, regulations

In accordance with the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.) the Department of Health shall establish rules and regulations:

a. For the annual reporting by health care institutions, and the gathering of such additional data as is reasonably necessary to oversee and evaluate the implementation of this act. The department shall seek to minimize the burdens of record-keeping imposed by the rules and regulations and shall seek to assure the appropriate confidentiality of patient records.

b. Requiring health care institutions to adopt policies and practices designed to:

(1) Make routine inquiry, at the time of admission and at such other times as are appropriate under the circumstances, concerning the existence and location of an advance directive;

(2) Provide appropriate informational materials concerning advance directives to all interested patients and their families and health care representatives, and to assist patients interested in discussing and executing an advance directive;

(3) Educate patients and their families and health care representatives about the availability, benefits and burdens of rehabilitative treatment, therapy and services, as appropriate;

(4) Inform physicians, nurses, and other health care professionals of their rights and responsibilities under this act, to assure that the rights and responsibilities are understood, and to provide a forum for discussion and consultation regarding the requirements of this act; and

(5) Otherwise comply with the provisions of this act.

§ 26:2H-72. Evaluation of implementation of act; report [Repealed]

This section was repealed by L. 2007, c. 39, § 1, eff. Jan. 29, 2007.

§ 26:2H-73. Immunities

a. A health care representative shall not be subject to criminal or civil liability for any actions performed in good faith and in accordance with the provisions of this act to carry out the terms of an advance directive.

b. A health care professional shall not be subject to criminal or civil liability or to discipline by the health care institution or the respective State licensing board for professional misconduct for any actions performed in good faith and in accordance with the provisions of this act, any rules and regulations established by the Department of Health pursuant to this act, and accepted professional standards to carry out the terms of an advance directive.

c. A health care institution shall not be subject to criminal or civil liability for any actions performed in good faith and in accordance with the provisions of this act to carry out the terms of an advance directive.

§ 26:2H-74. Absence of advance directive, act not applicable

The absence of an advance directive shall create no presumption with respect to a patient's wishes regarding the provision, withholding or withdrawing of any form of health care. The provisions of this act do not apply to persons who have not executed an advance directive.

§ 26:2H-75. Advance directive shall not affect insurance, benefits coverage

The execution of an advance directive pursuant to this act shall not in any manner affect, impair or modify the terms of, or rights or obligations created under, any existing policy of health insurance, life insurance or annuity, or governmental benefits program. No health care practitioner or other health care provider, and no health service plan, insurer, or governmental authority, shall deny coverage or exclude from the benefits of service any individual because that individual has executed or has not executed an advance directive. The execution, or non-execution, of an advance directive shall not be made a condition of coverage under any policy of health insurance, life insurance or annuity, or governmental benefits program.

§ 26:2H-76. Advance directive executed in other jurisdictions, validity

An advance directive executed under the laws of another state in compliance with the laws of that state or the State of New Jersey is validly executed for purposes of this act. An advance directive executed in a foreign country in compliance with the laws of that country or the State of New Jersey, and not contrary to the public policy of this State, is validly executed for purposes of this act.

§ 26:2H-77. Applicability of other law

a. The withholding or withdrawing of life-sustaining treatment pursuant to section 15 of this act, when performed in good faith, and in accordance with the terms of an advance directive and the provisions of this act, shall not constitute homicide, suicide, assisted suicide, or active euthanasia.

b. To the extent any of the provisions of this act are inconsistent with P.L.1971, c.373 (C.46:2B-8 et seq.) concerning the designation of a health care representative, the provisions of this act shall have priority over those of P.L.1971, c.373 (C.46:2B-8 et seq.).

Durable powers of attorney for health care executed pursuant to P.L.1971, c.373 (C.46:2B-8 et seq.) prior to the effective date of this act shall have the same legal force and effect as if they had been executed in accordance with the provisions of this act.

c. Nothing in this act shall be construed to impair the rights of emancipated minors under existing law.

§ 26:2H-78. Violations, penalties

a. A health care professional who intentionally fails to act in accordance with the requirements of this act is subject to discipline for professional misconduct pursuant to section 8 of P.L.1978, c.73 (C.45:1-21).

b. A health care institution that intentionally fails to act in accordance with the requirements of this act shall be subject to a fine of not more than $ 1,000 for each offense. For the purposes of this subsection, each violation shall constitute a separate offense. Penalties for violations of this act shall be recovered in a summary civil proceeding, brought in the name of the State in a court of competent jurisdiction pursuant to "the penalty enforcement law" (N.J.S. 2A:58-1 et seq.).

c. The following acts constitute crimes:

(1) To willfully conceal, cancel, deface, obliterate or withhold personal knowledge of an advance directive or a modification or revocation thereof, without the declarant's consent, is a crime of the fourth degree.

(2) To falsify or forge an advance directive or a modification or revocation thereof of another individual is a crime of the fourth degree.

(3) To coerce or fraudulently induce the execution of an advance directive or a modification or revocation thereof is a crime of the fourth degree.

(4) To require or prohibit the execution of an advance directive or a modification or revocation thereof as a condition of coverage under any policy of health insurance, life insurance or annuity, or governmental benefits program, or as a condition of the provision of health care is a crime of the fourth degree.

d. Commission of any of the acts identified in paragraphs (1), (2), or (3) of subsection c., resulting in the involuntary earlier death of a patient, shall constitute a crime of the fourth degree.

e. The sanctions provided in this section shall not be construed to repeal any sanctions applicable under other law.